January 1 – December 31, 2014

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of the Tennessee Valley Authority Medicare Prescription Drug Plan (Employer PDP)

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2014. It explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Tennessee Valley Authority Medicare Prescription Drug Plan Catamaran Member Services Center:
For help or information, please call the Catamaran Member Services Center or go to our plan website at www.mycatamaranrx.com (after your effective date of coverage).

1-855-207-5871
TTY users call: 711

Calls to these numbers are free.
Hours of Operation:
24 hours a day, 7 days a week

This plan is offered by the *Tennessee Valley Authority*, referred throughout the Evidence of Coverage as "we," "us," or "our." The Tennessee Valley Authority Medicare Prescription Drug Plan is referred to as "plan" or "our plan."

Catamaran is a Medicare approved Part D sponsor and administers this plan on behalf of the Tennessee Valley Authority.

If you need this information in other formats, such as Braille, large print or audio, please contact Catamaran Member Services.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2015.

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Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member of the Tennessee Valley Authority Medicare Prescription Drug Plan

SECTION 1 Introduction

Section 1.1 What is the Evidence of Coverage booklet about?

This Evidence of Coverage booklet tells you how to use your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan is offered by the Tennessee Valley Authority, referred throughout the Evidence of Coverage as "we," "us," or "our." The Tennessee Valley Authority Medicare Prescription Drug Plan is referred to as "plan" or "our plan."

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of the Tennessee Valley Authority Medicare Prescription Drug Plan.

Section 1.2 What does this Chapter tell you?

Look through Chapter 1 of this Evidence of Coverage to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan's service area?
- How do you keep the information in your member records up to date?

Section 1.3 What if you are new to the Tennessee Valley Authority Medicare Prescription Drug Plan?

If you are a new member, then it's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact Catamaran Member Services Center (contact information is on the cover of this booklet).

Section 1.4 Legal information about the Evidence of Coverage

It's part of our contract with you

This Evidence of Coverage is part of our contract with you about how the Tennessee Valley Authority Medicare Prescription Drug Plan covers your care. Other parts of this contract include the List of Covered Drugs (Formulary) and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in the Tennessee Valley Authority Medicare Prescription Drug Plan between January 1, 2014 to December 31, 2014.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for coverage in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are entitled to Medicare Part A and you are enrolled in Medicare Part B (**you must have both Part A and Part B**)
- Your former employer or your retiree group has enrolled you in this plan

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.

- Medicare Part B is for most other medical services, such as physician's services and other outpatient services and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for the Tennessee Valley Authority Medicare Prescription Drug Plan

Although Medicare is a Federal program, Tennessee Valley Authority is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described. Our service area includes: All 50 states, the District of Columbia, Puerto Rico and Guam.

If you plan to move out of the service area, please contact Catamaran Member Services (phone numbers are printed on the front cover of this booklet).

SECTION 3 What other materials will you get from us?

Section 3.1 Your member identification (ID) card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use our ID card for prescription drugs you get at network pharmacies.

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your ID card is damaged, lost, or stolen, call the Catamaran Member Services Center right away and we will send you a new card.

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The Pharmacy Directory and Pharmacy Locator tool: your guide to pharmacies in our network

What are "network pharmacies"?

Our Pharmacy Directory gives you a list of our network pharmacies – that means the pharmacies that have agreed to fill covered prescriptions for our plan members. You can also locate pharmacies on our website at www.mycatamaranrx.com (available after January 1, 2014) using the pharmacy locator tool.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies. If you use a non-participating pharmacy, you may pay more for your prescriptions.

The pharmacy network listing can be found on our website at www.mycatamaranrx.com (after your effective date of coverage). Or, you can contact the Catamaran Member Services Center for more information.

Section 3.3 The plan's List of Covered Drugs (Formulary)

The plan has a List of Covered Drugs (Formulary) for the 2014 plan year. We call it the "Drug List." It tells which Part D prescription drugs are covered by the Tennessee Valley Authority

Medicare Prescription Drug Plan. The drugs on this list are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.

The Drug List will arrive with your ID card, and is also available for your reference on our website at www.mycatamaranrx.com (after your effective date of coverage). To request an additional copy of this listing be mailed to you, please contact the Catamaran Member Services Center.

Section 3.4 The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your prescription drugs

When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the *Explanation of Benefits*.

The Explanation of Benefits tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact the Catamaran Member Services Center.

SECTION 4 Your monthly premium for the Tennessee Valley Authority Medicare Prescription Drug Plan

Section 4.1 How much is your plan premium?

Your coverage is provided through a contract with your former employer or your retiree group. Your group benefits administrator determines how your plan premium is paid. If you have questions about your plan premium, please contact your group benefits administrator for more information.

If your former employer or your retiree group charges you a plan premium or a portion of the plan premium, you are required to pay the premium according to their instructions.

If your former employer or your retiree group has not received your plan premium when it is due, a notice will be sent to you telling you that plan membership will end if they do not receive your plan premium within the grace period determined by your former employer or retiree group.

If your membership is ended due to nonpayment of premiums, you will have coverage under Original Medicare. At the time your membership is ended, premiums that have not been paid may still be owed to your former employer or your retiree group. If this occurs and you want to enroll again in our plan, contact your group benefits administrator. Any past-due premiums may need to be paid before they can re-enroll you.

If you think your membership has been wrongfully ended, please contact your group benefits administrator to determine what steps you need to follow to have your coverage reinstated. **Chapter 7** of this booklet tells how to make a complaint. In addition, you must continue to pay any applicable Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, enrolling in the program might reduce your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this Evidence of Coverage may not apply to you**. You will receive a separate notification that tells you about your drug coverage. If you are already enrolled and getting help from one of these programs and don't receive this notification, please call the Catamaran Member Services Center and ask for your "LIS Rider" (the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs.) Phone numbers for the Catamaran Member Services Center are on the front cover.

In some situations, your plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't keep their creditable coverage. For these members, the plan's monthly premium may be higher. It will be the monthly plan premium plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.

Note: If you have a late enrollment penalty, it may be part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in October and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for Extra Help or if you lose your eligibility for Extra Help

during the year. If a member qualifies for Extra Help with their prescription drug costs, Extra Help will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in Chapter 2, Section 7.

SECTION 5 Please keep your member records up to date

Section 5.1 How to help make sure that we have accurate information about you

The pharmacists in the plan's network need to have correct information about you. **These network providers use your member record to know what drugs are covered for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

Read over the information we send you about any other insurance coverage you have.

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call the Catamaran Member Services Center.

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

Chapter 2. Important phone numbers and resources

SECTION 1 Tennessee Valley Authority Medicare Prescription Drug Plan contacts (how to contact us, including how to reach the Catamaran Member Services Center)

How to contact our plan's Catamaran Member Services Center and other important departments.

For assistance with claims, billing or ID card questions, please call the Catamaran Member Services Center. The Catamaran Member Services Center is available 24 hours a day, 7 days a week, or please visit our website at www.mycatamaranrx.com (after your effective date of coverage). We will be happy to help you.

	Phone	TTY*	Fax	Mailing Address
Catamaran Member Services Center	1-855-207-5871	711	1-866-235-3171	Catamaran Attn: Catamaran Member Services P.O. Box 3410 Lisle, IL 60532
Coverage Decisions	1-855-207-5871	711	1-866-511-2202	Catamaran Attn: Prior Auth Part D Exceptions P.O. Box 5252 Lisle, IL 60532
Appeals	1-855-207-5871	711	1-866-511-2202	Catamaran Attn: Part D Appeals P.O. Box 5252 Lisle, IL 60532
Comments/ Complaints	1-855-207-5871	711	1-866-235-3171	Catamaran Attn: Part D Grievances P.O. Box 3410 Lisle, IL 60532
Payment Requests	1-855-207-5871	711	1-866-713-6511	Catamaran Attn: Manual Claims PO Box 968021 Schaumburg, IL 60196-8021

**This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.*

SECTION 2 **Medicare** (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Prescription Drug Plans, including us.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

State Health Insurance Assistance Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization for each state.

Quality Improvement Organizations have a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Quality Improvement Organizations are independent organizations. It is not connected with our plan.

You should contact a QIO if you have a complaint about the quality of care you have received. For example, you can contact a QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use our automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am ET to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- Qualified Individual (QI): Helps pay Part B premiums.
- Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help, call Social Security (see Section 5 of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see Section 6 of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because *Tennessee Valley Authority* offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 4, Section 6 for more information about your coverage during the Coverage Gap Stage.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount. The plan pays an additional 2.5% and you pay the remaining 47.5% for your brand drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 21% of the price for generic drugs and you pay the remaining 72% of the price. The coverage for generic drugs works differently than the coverage for brand name drugs. For generic drugs, the amount paid by the plan (21%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Catamaran Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. Also, the plan pays 2.5% of the costs of brand drugs in the coverage gap. The 50% discount and the 2.5% paid by the plan is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn’t appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get prescription drug benefits through an employer/union or retiree group **other than the Tennessee Valley Authority**, call that employer/union benefits administrator if you have any questions. You can ask about their employer/retiree health or drug benefits, premiums, or enrollment period.

Important Note: Your (or your spouses') employer/union benefits may change, or you or your spouse may lose the benefits, if you or your spouse enrolls in a Medicare Part D program. Call that employer/union benefits administrator to find out whether the benefits will change or be terminated if you or your spouse enrolls in a Part D plan.

Chapter 3. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

To find out more about this coverage, see your *Medicare & You* handbook.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy.*)

Your drug must be on the plan's List of Covered Drugs (Formulary). We call it the "Drug List". (See Section 3, *Your drugs need to be on the plan's drug list*.)

Your drug must be considered "medically necessary", meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

A network pharmacy is a pharmacy that has agreed to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the plan.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Pharmacy Directory included in this packet, or visit our website at www.mycatamaranrx.com (after your effective date of coverage), or call the Catamaran Member Services Center. Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a doctor or, if applicable/allowed, to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from the Catamaran Member Services Center or use the Pharmacy Directory.

What if you need a non-retail (or Specialized), network pharmacy?

Sometimes prescriptions must be filled at a non-retail, network pharmacy. Non-retail, network pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact the Catamaran Member Services Center.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense certain drugs that are restricted by the FDA to certain locations, require extraordinary handling, provider coordination, or education on its use. (Note: This scenario should happen rarely.)

To locate a non-retail, network pharmacy, call the Catamaran Member Services Center.

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. These drugs are marked as **"maintenance" drugs** on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

To get order forms and information about filling your prescriptions by mail, please call the Catamaran Member Services Center or visit the website at: www.mycatamaranrx.com (after your effective date of coverage). If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 14 days. However, if mail order is delayed, please call the Catamaran Member Services Center and an interim fill at your retail pharmacy can be arranged for you.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers a way to get a long-term supply of "maintenance" drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs: Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Catamaran Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services. Our plan's mail-order service requires you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription might be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail service pharmacy (including high-cost and unique drugs).
- If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy service. If you are traveling within the United

States and need to fill a prescription because you become ill or you lose or run out of your covered medications, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules. Prior to filling your prescription at an out-of-network pharmacy, call the Member Service numbers listed on the back of your Member ID card to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Member Service may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to an in-network pharmacy. If you do go to an out-of-network pharmacy for any of the reasons listed above, the Plan will cover up to a one-month supply of drugs.

In these situations, **please check first with the Catamaran Member Services Center** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you may have to pay a higher amount, or the full cost, (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "2014 List of Covered Drugs (Formulary)." In this Evidence of Coverage, **we also call it the "Drug List."**

The drugs on this list are selected with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare.

The drugs on the Drug List are only those covered under this Medicare Part D plan (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

The Drug List includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. It works just as well as the brand-name drug, but it costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the Drug list?

The plan does not cover all prescription drugs.

In some cases, the law does not allow any Medicare plan to cover certain types of drugs.

In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are four "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-Sharing Tier 1 includes Generic drugs. This is the lowest cost-sharing tier.
- Cost-Sharing Tier 2 includes Preferred Brand drugs. This is the moderate cost-sharing tier.
- Cost-Sharing Tier 3 includes Non-Preferred Brand drugs. This is the highest cost-sharing tier.
- Cost-Sharing Tier 4 includes Specialty drugs. This tier has a coinsurance.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs).*

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

Visit the plan's website (www.mycatamaranrx.com (after your effective date of coverage)).

Check the most recent Drug List which will be included with your ID card. (Please note: The Drug List we send includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Catamaran Member Services to find out if we cover it.)

Call the Catamaran Member Services Center to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor or other prescriber to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections to follow tell you more about the types of restrictions we use for certain drugs.

Using generic drugs whenever you can

A "generic" drug works the same as a brand-name drug, but usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies must provide you the generic version.** However, if your doctor has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your doctor need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization.**" Sometimes plan approval is required so we can be sure that your drug is covered by Medicare rules. Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try safer or more effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may

require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**Step Therapy**."

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply a drug you take or want to take, check the Drug List. For the most up-to-date information, call the Catamaran Member Services Center or check our website (www.mycatamaranrx.com (after your effective date of coverage)).

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your doctor think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

What if the drug you want to take is not covered by the plan? For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.

What if the drug is covered, but there are extra rules or restrictions on coverage for that drug? As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.

What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be? The plan puts each covered drug into one of four different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply) until you and your doctor decide it is okay to change to another drug, or while you file an exception.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug covered.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your doctor about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

The drug you have been taking is **no longer on the plan's Drug List**.

– or –

The drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

For those members who were in the plan last year:

We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For those members who are new to the plan and aren't in a long-term care facility:

We will cover a temporary supply of your drug **one time only during the first 90 days of your enrollment** in the plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For those who are new members, and are residents in a long-term care facility:

We will cover a temporary supply of your drug **during the first 90 days of your enrollment** in the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

For those who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:

We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call the Catamaran Member Services Center (phone numbers are on the front cover).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call the Catamaran Member Services Center to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor or other prescriber can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call the Catamaran Member Services Center to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor or other prescriber to find a covered drug that might work for you.

You can file an exception

You and your doctor or other prescriber can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule.

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, there may be changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand-name drug with a generic drug.**
- In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your doctor will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.
- If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
- During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
- Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
- Your doctor or other prescriber will also know about this change, and can work with you to find another drug for your condition.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are not covered.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Sometimes "off-label use" is allowed. Coverage is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."
- Also, by law, these categories of drugs are not covered by Medicare drug plans:
- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates, except when used to treat epilepsy, cancer, or a chronic mental health disorder

In addition, if you are **receiving extra help from Medicare** to pay for your prescriptions, the extra help will not pay for the drugs not normally covered. (Please refer to your formulary or call the Catamaran Member Services Center for more information.) Your state Medicaid program *may* cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

SECTION 8 Show your member identification (ID) card when you fill a prescription

Section 8.1 Show your ID card

To fill your prescription, show your plan member ID card at the network pharmacy you choose. When you show your ID card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your ID card with you?

If you don't have your ID card with you when you fill your prescription, ask the pharmacy to call the Catamaran Member Services Center (phone numbers are on the front cover) to get the necessary information. If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 8, *Ending your coverage in the plan*, tells how you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

If you need more information about a particular long-term care facility, please check your *Pharmacy Directory*, or contact the Catamaran Member Services Center.

What if you're a resident in a long-term care facility and become a new member of the plan?

If you are a new member and a resident of a long-term care facility, and you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your enrollment. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 7 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in the Tennessee Valley Authority Medicare Prescription Drug Plan doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it.

Some drugs may be covered under Medicare Part B in some situations and through the Tennessee Valley Authority Medicare Prescription Drug Plan in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or the Tennessee Valley Authority Medicare Prescription Drug Plan for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice by November 15 that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, of if you can't find it, contact your Medicare insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your spouse's employer or retiree group, other than with Tennessee Valley Authority? If so, please contact **that group's benefits administrator.** They can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your other employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your doctor to correct the problem.

Section 10.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

Chapter 4. What you pay for your Part D prescription drugs

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, some drugs are covered under Original Medicare or are excluded by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

The plan's List of Covered Drugs (Formulary). To keep things simple, we call this the "Drug List."

The Drug List tells which drugs are covered for you.

It also tells which of the four "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.

If you need a copy of the Drug List, call the Catamaran Member Services Center. You can also find the Drug List on our website at www.mycatamaranrx.com (after your effective date of coverage).

Chapter 3 of this booklet. Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.

The plan's Pharmacy Directory. In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The Pharmacy Directory has a list of pharmacies in the plan's network.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the four drug payment stages?

As shown in the table below, there are four "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	***Stage 2*** *Initial Coverage Stage*	***Stage 3*** *Coverage Gap Stage*	***Stage 4*** *Catastrophic Coverage Stage*
If your plan has a deductible, you begin in this stage when you fill your first prescription of the plan year. During this stage, you pay the full cost of your drugs. You stay in this stage until you have paid the deductible listed in other plan documents you have received. (Details are in Section 4 of this chapter.)	During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. Your share of the cost is shown in other plan documents you have received. After you (or others on your behalf) have met your deductible (if your plan has a deductible), the plan pays its share of the cost of your drugs and you pay your share. You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $2,850. (Details are in Section 5 of this chapter.)	Refer to other plan documents you have received to determine if your plan has a Coverage Gap and what you and the plan will pay during this stage. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of $4,550. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, the plan will pay most of the cost of your drugs for the rest of the plan year (through December 31, 2014). (Details are in Section 7 of this chapter.)

As shown in this summary of the four payment stages, whether you move on to the next payment stage depends on how much **you spend** for your drugs.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Explanation of Benefits"

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you

when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.

We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the Explanation of Benefits (it is sometimes called the "EOB") when you have had one or more prescriptions filled. It includes:

Information for that month. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.

Totals for the year since January 1. This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

Show your member ID card when you get a prescription filled. To make sure we know about the prescriptions you are filling and what you are paying, show your plan ID card every time you get a prescription filled.

Make sure we have the information we need. There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

Send us information about the payments others have made for you. Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

Check the written report we send you. When you receive an Explanation of Benefits in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at the Catamaran Member Services Center. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid $200 for your drugs

Once you have paid your deductible, you move onto the Initial Coverage Stage.

The Deductible stage is the first payment stage for your drug coverage. This stage begins when you fill your first applicable prescription of the plan year. You will pay a yearly deductible in the amount listed in other plan documents you have received. When you are in this payment stage, **you must pay the full cost of your drugs that apply to your deductible** until you reach the plan's deductible amount. Please refer to other plan documents you have received to determine the amount of your deductible and to which drugs your deductible applies.

- Your **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **deductible** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid the applicable deductible, you leave the Deductible stage and move on to the next drug payment stage, which is the Initial Coverage stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During this phase, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has four Cost-Sharing Tiers

Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1 includes Generic drugs. This is the lowest cost-sharing tier.

- Cost-Sharing Tier 2 includes Preferred Brand drugs. This is the moderate cost-sharing tier.
- Cost-Sharing Tier 3 includes Non-Preferred Brand drugs. This is the highest cost-sharing tier.
- Cost-Sharing Tier 4 includes Specialty drugs. This tier has a coinsurance.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and reference the plan's Pharmacy Directory or Pharmacy Locator tool.

Section 5.2 A table that shows your costs for a 30-day and 90-day supply of a drug

During the Initial Coverage (Initial) Stage, your share of the cost of a covered drug will be a copayment.

"Copayment" means that you pay a fixed amount each time you fill a prescription.

"Coinsurance" means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which tier your drug is in.

Your share of the cost when you get Covered Part D prescription drugs from:

	Retail Network pharmacy – 31 day supply	Retail Network pharmacy – 90 day supply	The plan's mail-order service
Cost-Sharing Tier 1 (Generic drugs)	$10	$20	$20
Cost-Sharing Tier 2 (Preferred Brand drugs)	$40	$80	$80
Cost-Sharing Tier 3 (Non-Preferred Brand drugs)	$80	$120	$120
Cost-Sharing Tier 4 (Specialty drugs)	$80	$120	Not Covered

Section 5.3 You stay in the Initial Coverage Stage until your out-of-pocket costs have reached the $2,850 limit for the calendar year

You stay in the Initial Coverage Stage until your out-of-pocket costs have reached the $2,850 limit for the calendar year.

The Explanation of Benefits that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the $2,850 limit in a year.

We will let you know if you reach this $2,850 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

What you have paid for all the covered drugs you have gotten since you started with your first drug purchase of the plan year. (See **Section 6.2** for more information about how Medicare calculates your out-of-pocket costs.) This includes:

- The deductible you paid when you were in the Deductible stage (if applicable).
- The total you paid as your share of the cost for your drugs during the Initial Coverage stage.

What the plan has paid as its share of the cost for your drugs during the Initial Coverage stage. (If you were enrolled in a different Part D plan at any time during 2013, the amount that plan paid during the Initial Coverage stage also counts toward your total drug costs.)

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 72% of the costs for generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $4,550

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 47.5% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 72% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (28%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 72% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2014, that amount is $4,550.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,550, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

*These payments **are** **included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage.
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $4,550 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

*These payments are **not** included in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $4,550 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,550 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:
- either – coinsurance of 5% of the cost of the drug, not to exceed the standard copayment amount during the Initial Coverage stage
– or – $2.55 copayment for a generic drug or a drug that is treated like a generic. Or a $6.35 copayment for all other drugs.
Our plan pays the rest of the cost.

SECTION 8 What you pay for vaccinations depends on how and where you get them

Section 8.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's List of Covered Drugs.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot.

Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and administration of the vaccine.

Situation 2: You get the vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Section 8.2 You may want to call us at the Catamaran Member Services Center before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at the Catamaran Member Services Center whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D "late enrollment penalty"?

Section 9.1 What is the Part D "late enrollment penalty"?

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't keep your prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards.) The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in the Tennessee Valley Authority Medicare Prescription Drug Plan, we let you know the amount of the penalty.

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

Section 9.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty

is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2013, this average premium amount was $31.08. This amount may change for 2014.

To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $31.08, which equals $4.35. This rounds to $4.40. This amount would be added to the monthly premium for someone with a late enrollment penalty.

There are three important things to note about this monthly late enrollment penalty:

First, the penalty may change each year, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.

Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.

Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

You already have prescription drug coverage at least as good as Medicare's standard drug coverage. Medicare calls this "**creditable drug coverage**." Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare's.

Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

For additional information about creditable coverage, please look in your *Medicare & You* 2014 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

If you were without creditable coverage, but you were without it for less than 63 days in a row.

If you are receiving "Extra Help" from Medicare.

Section 9.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the letter you receive stating you have to pay a late enrollment penalty. Call the Catamaran Member Services Center at the number on the front of this booklet to find out more about how to do this.

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2012 was:	If you were married but filed a separate tax return and your income in 2012 was:	If you filed a joint tax return and your income in 2012 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$11.60
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$29.90
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$48.30
Greater than $214,000	Greater than $129,000	Greater than $428,000	$66.60

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 10.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

Chapter 5. Asking the plan to pay its share of the costs for covered drugs

SECTION 1 Situations in which you should ask our plan to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). Asking for reimbursement in the first three examples below are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

Here are examples of situations in which you may need to ask our plan to pay you back:

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please call Catamaran Member Services for more information).

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription because you don't have your ID card with you

If you do not have your plan ID card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you may need to pay if you do not have your card.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Customer Care for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Care are printed on the back cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*, has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

You don't have to use the form, but it's helpful for our plan to process the information faster.

Either download a copy of the form from our website www.mycatamaranrx.com (after your effective date of coverage) or call the Catamaran Member Services Center and ask for the form. The phone numbers for the Catamaran Member Services Center are on the cover of this booklet.

Mail your request for payment together with any receipts to us at this address:

Catamaran
Attn: Manual Claims
PO Box 968021
Schaumburg, IL 60196-8021

You must submit your claim to us within 30 of the date you received the service, item, or drug.

Please be sure to contact the Catamaran Member Services Center if you have any questions. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of all but our share to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs.)

If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for the drug, you can make an appeal

If you think we have made a mistake in turning you down, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you don't have your plan member ID card with you
- When you pay the full cost for a prescription in other situations

For the details on how to make this appeal, go to Chapter 7 of this booklet, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*. The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives

definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in Deductible Stage and Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.

Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.

Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Please note: If you are in the Deductible Stage and Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

Please note: Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy

of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you

Our plan has people and translation services available to answer questions from non-English speaking members. Our Catamaran Member Services Center has special telephone equipment that is used for people who have difficulties with hearing or speaking. We can also give you information in Braille, in large print, or other alternate formats if you need it.

Plan information is available for your reference on our website at www.mycatamaranrx.com (after your effective date of coverage). To request plan information be mailed to you, please call the Catamaran Member Services Center (phone numbers are on the front cover).

Sección 1.1 Debemos brindar información de tal forma que le sea útil

Para obtener información nuestra de tal forma que le sea útil, llame al Servicio al Cliente (los números de teléfono están en la portada de este folleto).

Nuestro plan cuenta con servicios disponibles de intérprete de idiomas sin cargo y personas para responder preguntas de miembros que no hablan inglés. Además, podemos brindarle información en braille u otros formatos alternativos si a necesita. Si es elegible para Medicare debido a una incapacidad, debemos brindarle información sobre los beneficios del plan que es accesible y adecuado para usted.

Si tiene problemas para obtener información de nuestro plan debido a problemas relacionados con el idioma o incapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana, e infórmeles que desea presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us the Catamaran Member Services Center. If you have a complaint, such as a problem with wheelchair access, the Catamaran Member Services Center can help.

Section 1.3 We must ensure that you get timely access to your covered drugs

As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 of this booklet tells what you can do.

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

We make sure that unauthorized people don't see or change your records.

In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

For example, we are required to release health information to government agencies that are checking on quality of care.

Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call the Catamaran Member Services Center.

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call the Catamaran Member Services Center:

Information about our plan. This includes, for example, the Annual Notice of Changes, List of Covered Drugs (Formulary) and more. Plan information is available for your reference on our website at www.mycatamaranrx.com (after your effective date of coverage). To request that a copy of plan information be mailed to you, please contact the Catamaran Member Services Center.

Information about our network pharmacies. You have the right to get information from us about the pharmacies in our network. For a list of the pharmacies in the plan's network, see the Pharmacy Directory. For more detailed information about our pharmacies, you can call the Catamaran Member Services Center or visit our website at www.mycatamaranrx.com (after your effective date of coverage).

Information about your coverage and rules you must follow in using your coverage. To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet, plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs. If you have questions about the rules or restrictions, please call the Catamaran Member Services Center.

Information about why something is not covered and what you can do about it. If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.

If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.) If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.
- The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.
- If you want to use an "advance directive" to give your instructions, here is what to do:
- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the State Department of Health.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call the Catamaran Member Services Center.

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call the Catamaran Member Services Center**.
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call the Catamaran Member Services Center**.
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.

- You can visit the Medicare website (www.medicare.gov) to read or download the publication "Your Medicare Rights & Protections."
- Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call the Catamaran Member Services Center. We're here to help.

Get familiar with your covered drugs and the rules you must follow to get these covered drugs. *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.*

Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.

If you have any other prescription drug coverage besides our plan, you are required to tell us. *Please call the Catamaran Member Services Center to let us know.*

We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it.

Tell your doctor and pharmacist that you are enrolled in our plan. *Show your plan ID card whenever you get your Part D prescription drugs.*

Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.

To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.

If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

Pay what you owe. *As a plan member, you are responsible for these payments:*

You must pay your plan premiums (if applicable) to continue being a member of our plan.

For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost) Chapter 4 tells what you must pay for your Part D prescription drugs.

If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.

Tell us if you move. *If you are going to move, it's important to tell us right away.*

Call the Catamaran Member Services if you move so that your member records are up to date and we know how to contact you.

Call the Catamaran Member Services Center for help if you have questions or concerns. *We also welcome any suggestions you may have for improving our plan.*

Phone numbers and calling hours for the Catamaran Member Services Center are on the cover of this booklet.

For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

COVERAGE DECISIONS AND APPEALS

MAKING COMPLAINTS

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call the Catamaran Member Services Center. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and making appeals."**	Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage, or about the amount we will pay for your prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. Usually, there is no problem. We decide the drug is covered and pay our share of the cost. But in some cases we might decide the drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

You **can call us at the Catamaran Member Services Center**.

To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

You should consider getting your doctor or other prescriber involved if possible, especially if you want a "fast" or "expedited" decision. In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives").

You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

There may be someone who is already legally authorized to act as your representative under State law.

If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call the Catamaran Member Services Center and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.

You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's List of Covered Drugs (Formulary) and they are medically necessary for you, as determined by your primary care doctor or other provider.

This section is about your Part D drugs only. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.

For details about what we mean by Part D drugs, the List of Covered Drugs, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your Part D drugs is called a "**coverage determination.**"

Here are examples of coverage decisions you ask us to make about your Part D drugs:
You ask us to make an exception, including:

- Asking us to cover a Part D drug that is not on the plan's List of Covered Drugs
- Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's List of Covered Drugs but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.
- If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter.	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.	Do you want to ask us to pay you back for a drug you have already received and paid for? You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

Covering a Part D drug for you that is not on our plan's List of Covered Drugs (Formulary). We call it the "Drug List."

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to the drug. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

You cannot ask for coverage of any "excluded drugs" or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

Removing a restriction on the plan's coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on the plan's List of Covered Drugs (for more information, go to Chapter 3).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

The extra rules and restrictions on coverage for certain drugs include:

- *Being required to use the generic version* of a drug instead of the brand-name drug.
- *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
- *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
- *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.

If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on the plan's Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

If your drug is in Tier 3 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2. This would lower your share of the cost for the drug.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do:

Request the type of coverage decision you want. Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*

You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

If you want to ask our plan to pay you back for a drug, start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It

also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

If you are requesting an exception, provide the "doctor's statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 5.2 and 5.3 for more information about exception requests.

If your health requires it, ask us to give you a "fast decision"

Legal Terms	A "fast decision" is called an **"expedited decision."**

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.

To get a fast decision, you must meet two requirements:

You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)

You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.

If you ask for a fast decision on your own (without your doctor's or other prescriber's support), our plan will decide whether your health requires that we give you a fast decision.

If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).

This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.

The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: Our plan considers your request and we give you our answer.

Deadlines for a "fast" coverage decision

If we are using the fast deadlines, we must give you our answer **within 24 hours**.

Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision about a drug you have not yet received

If we are using the standard deadlines, we must give you our answer **within 72 hours.**

Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

If our answer is yes to part or all of what you requested –

If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

We must give you our answer within **14 calendar days** after we receive your request.

If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

If our answer is yes to part or all of what you requested

If we approve your request for coverage, we are also required to make payment to you within **14 calendar days** after we receive your request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms	When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal." An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact our plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

To start your appeal, you (or your representative or your doctor or other prescriber) must contact our plan.

For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*

Make your appeal in writing by submitting a signed request.

If you are asking for a standard appeal, make your appeal by submitting a written request.

If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the Catamaran Member Services Center.

You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.

You can ask for a copy of the information in your appeal and add more information.

You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms	A "fast appeal" is also called an **"expedited appeal."**

If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."

The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in Section 5.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast" appeal

If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.

If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)

If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.

If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

If our answer is yes to part or all of what you requested

If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.

If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.

If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.

You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

The Independent Review Organization is an outside, independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.

Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast" appeal at Level 2

If your health requires it, ask the Independent Review Organization for a "fast appeal."

If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

If the Independent Review Organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard" appeal at Level 2

If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.

If the Independent Review Organization says yes to part or all of what you requested

If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved.

If the answer is no, the appeals process *may* or *may not* be over.

If you decide to accept this decision that turns down your appeal, the appeals process is over.

If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with you appeal. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved.

If the answer is no, the appeals process *may* or *may not* be over.

If you decide to accept this decision that turns down your appeal, the appeals process is over.

If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your

appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal. This is the last stage of the appeals process.

This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

Are you unhappy with the quality of the care you have received?

Respecting your privacy

Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

Has someone been rude or disrespectful to you?

Are you unhappy with how our Catamaran Member Services has treated you?

Do you feel you are being encouraged to leave the plan?

Waiting times

Have you been kept waiting too long by pharmacists? Or by our Catamaran Member Services or other staff at the plan?

Examples include waiting too long on the phone or when getting a prescription.

Cleanliness

Are you unhappy with the cleanliness or condition of a pharmacy?

Information you get from us

Do you believe we have not given you a notice that we are required to give?

Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.

If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.

When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.

When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

What this section calls a **"complaint"** is also called a **"grievance."**

Another term for **"making a complaint"** is **"filing a grievance."**

Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

Usually, calling the Catamaran Member Services Center is the first step. If there is anything else you need to do, the Catamaran Member Services Center will let you know. Call Catamaran Member Services at 1-855-207-5871. TTY users call 711. Calls to these numbers are free. The Catamaran Member Services Center is available 24 hours a day, 7 days a week.

For more information about the Medicare Grievance Process, call the Catamaran Member Services Center.

If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you do this, it means that we will use our *formal procedure* for answering grievances. Here's how it works:

Send your compliant in writing and mail it to us at:

Catamaran
Attn: Part D Grievances
P.O. Box 3410
Lisle, IL 60532-3410

Whether you call or write, you should contact the Catamaran Member Services Center right away. The complaint must be made within 60 days after you had the problem you want to complain about.

If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called a **"fast grievance."**

Step 2: We look into your complaint and give you our answer.

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

Most complaints are answered in 30 days, but we may take up to 44 days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

You can make your complaint to the Quality Improvement Organization. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.

Or you can make your complaint to both at the same time. If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Chapter 8. Ending your coverage in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in the Tennessee Valley Authority Medicare Prescription Drug Plan may be *voluntary* (your own choice) or *involuntary* (not your own choice):

You might leave our plan because you have decided that you want to leave.

The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how and when* to end your membership in each situation.

There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your coverage.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period or the Special Enrollment Period

Usually, you can end your membership during Medicare's Annual Enrollment Period from October 15 to December 7 each year. This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

However, members of the Tennessee Valley Authority Medicare Prescription Drug Plan fall into a Special Enrollment Period because you are part of an Employer Group Waiver Plan, which means you are allowed to end your membership anytime throughout the year.

What can you do? You can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

Another Medicare prescription drug plan.

Original Medicare *without* a separate Medicare prescription drug plan.

– *or* – A Medicare Advantage plan. A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.

If you enroll in most Medicare Advantage plans, you will automatically be disenrolled from the Tennessee Valley Authority Medicare Prescription Drug Plan when your new plan's coverage

begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep the Tennessee Valley Authority Medicare Prescription Drug Plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is at least as good as Medicare's standard prescription drug coverage.)

When will your membership end? Your coverage will usually end on the first day of the month after we receive your request to change your plan.

Note: Before disenrolling from the Tennessee Valley Authority plan, you should first contact the plan you wish to enroll in and confirm that they will accept your application. If so, and they enroll you, you will automatically be disenrolled from the Tennessee Valley Authority plan.

Section 2.2 Where can you get more information about when you can end your enrollment?

If you have any questions or would like more information on when you can end your enrollment:

- You can **call the Catamaran Member Services Center.**
- You can find the information in the ***Medicare & You 2014*** handbook.
- Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
- You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 You end your membership by enrolling in another plan

To end your membership in our plan, you simply enroll in another Medicare plan. However, there are a couple of exceptions:

One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact the Tennessee Valley Authority and ask to be disenrolled from our plan.

Another exception is if you join a Private Fee-For-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan. In this case, you can enroll in that plan and keep the Tennessee Valley Authority Medicare Prescription Drug Plan

for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop your Medicare prescription drug coverage.

The table below explains how you should end your coverage in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
Another Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from the Tennessee Valley Authority Medicare Prescription Drug Plan when your new plan's coverage begins.
A Medicare health plan.	Enroll in the Medicare Advantage plan. With most Medicare Advantage plans, you will automatically be disenrolled from the Tennessee Valley Authority Medicare Prescription Drug Plan when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep the Tennessee Valley Authority Medicare Prescription Drug Plan for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* contact the Tennessee Valley Authority or Medicare and ask to be disenrolled.
Original Medicare *without* a separate Medicare prescription drug plan.	**Contact the Tennessee Valley Authority and ask to be disenrolled from the plan.** You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave the Tennessee Valley Authority Medicare Prescription Drug Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your prescription drugs through our plan.

You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

SECTION 5 The Tennessee Valley Authority Medicare Prescription Drug Plan must end your coverage in the plan in certain situations

Section 5.1 When must we end your coverage in the plan?

The Tennessee Valley Authority Medicare Prescription Drug Plan must end your coverage in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of the United States for more than twelve months.
- If you become incarcerated.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.
- We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your member ID card to get prescription drugs.
- If we end your coverage because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums.

We must notify you in writing to end your membership.

Where can you get more information?

You can call the **Catamaran Member Services Center** if you have questions or would like more information on when we can end your membership.

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your coverage. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Tennessee Valley Authority, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

Chapter 10. Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare. Section 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs Coinsurance is usually a percentage (for example, 20%).

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

Cost–Sharing Tier – Every drug on the list of covered drugs is in one of four cost-sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Catamaran Member Services Center – A department within our Plan responsible for answering your questions about your enrollment, benefits, grievances, and appeals. See Chapter 2 for information about how to contact the Catamaran Member Services Center.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Initial Coverage Stage) – The stage where you pay a copayment or coinsurance for your drugs until your out-of-pocket costs have reached the $2,850 limit for the calendar year.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

List of Covered Drugs (Formulary or "Drug List") – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy/Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Medically Necessary – Drugs that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – see "Medicare Advantage (MA) Plan".

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Plan Member/Member - (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2, Section 4 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.